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ABSTRACT

This Kids Count report examines issues related to children's mental health in Virginia. The report discusses the effects of children's mental illness, presents risk and protective factors, and describes the incidence of children's mental health problems. Information specific to Virginia is presented, including the prevalence of youth suicide, mental illness in incarcerated youth, and risks among children witnessing violence. The report also describes Virginia's service delivery system, details the system of care framework for mental health services, and describes the requirements of the Comprehensive Services Act of 1992. Issues affecting the availability and accessibility of services are examined, including lack of insurance parity, complexity and limits of Medicaid regulations, lack of public funding for services, and the stigma of mental illness. The consequences of stigma and scarce resources for children's mental health services are identified as designation of funds for specific limited populations, the lack of a continuum of services, forcing parents to relinquish custody of their children in order to access treatment, children committed to the Department of Juvenile Justice to access treatment, and the lack of prevention and early intervention efforts. The report concludes with the following recommendations for mental health services: (1) increase public awareness and knowledge of children's mental health issues; (2) increase the effectiveness of advocacy for children's mental health services; (3) increase the focus on prevention and early intervention services; and (4) establish community-level and state-level commitments to the system of care model. (Contains 106 endnotes.) (KB)

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SPECIAL REPORT

ISSUES IN CHILDREN'S MENTAL HEALTH

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Overview

What do we mean when we talk about children's mental health? Mental health refers to how children function psychologically on a day-to-day basis—how they think, feel, and act. The way they relate to others, feel about themselves, handle stress, and make choices are important components of mental health. It is helpful to think of mental health, like physical health, along a continuum. There are varying degrees of wellness and problems across the spectrum of mental health. And the degree of wellness or illness can vary over time—many children and adolescents experience mental health problems at some point during their growing-up years.[1]

Effects of Children's Mental Illness

A child or adolescent with mental health problems often has difficulty functioning at home, in school, or in the community. The child's problems also have an impact on the people around him or her—parents, siblings, and peers. Some parents cannot work because they are taking care of their children with mental illness; they do not have access to day care that is equipped to deal with their child's problems. Inordinate time spent caring for the child with emotional or behavioral problems means less time to spend with other children in the family. Parents raising a child with mental health problems often feel isolated from friends and neighbors because of the stigma of mental illness.[2]

Untreated mental illness in children and adolescents has dire consequences. Alarmingly, an estimated two-thirds of children with mental health disorders are not getting the treatment they need.[3] According to the National Institute of Mental Health, children with untreated emotional and cognitive disorders are at risk for school failure and dropping out, violence, and risky behaviors, including the risk of HIV transmission.[4] Drug abuse, suicide, and criminal activity are additional results of untreated disorders.[5] In Virginia, 73% of students with serious emotional handicaps do not complete high school.[6] National statistics show that nearly three-quarters of these dropouts are arrested within five years of leaving school.[7]

Risk and Protective Factors

Mental health problems occur in children of all races, socio-economic levels, and backgrounds, but there are certain factors that increase risk for mental disorders. Most research shows that the causes of children's mental health problems are a factor of both the child's own characteristics, such as genetic and biological factors, and the child's environment, including parents, siblings, peers, and the neighborhood or larger community.[8]

Biological risk factors include genetic risks—particularly for illnesses such as depression, autism, bipolar disorder, and schizophrenia—as well as biological abnormalities of the central nervous system, which can be caused by injury, infection, exposure to environmental toxins, and poor nutrition.[9] Prenatal exposure to alcohol, drugs, and cigarette smoke; traumatic brain injury; and malnutrition during pregnancy are all well-researched biological factors that have negative impacts on children's mental health.

Distressing childhood experiences also can create environmental risk factors for children. Dysfunctional family life, economic hardship, exposure to violence—both in the community and in the home—and poor parental attachment can all put children at greater risk for developing mental health disorders.[10] Child abuse and neglect have been linked to a variety of disorders, including depression, post-traumatic stress disorder, and conduct disorder.[11] Parents who suffer from depression or other mental illnesses may provide inadequate supervision of children or pay little attention to them, which can have negative effects on children's behavior.[12]

The extent to which these risk factors lead to serious mental health problems can be reduced or counterbalanced by the number of positive qualities or circumstances—called protective

factors—in a child's makeup and environment. Strong cognitive and social skills can help form a buffer between the child and risk factors. Positive and secure relationships with parents and friends and attendance at quality schools or after-school programs are also protective factors. According to a study on children exposed to domestic violence, "the most important protective resource to enable a child to cope with exposure to violence is a strong relationship with a competent, caring, positive adult, most often a parent."[13] (See page 5 for a discussion of children who witness violence.)

Number of Children Affected by Mental Health Problems

It is estimated that almost 21 percent of children in the US ages 9 to 17 have a diagnosable mental or addictive disorder with at least minimal impairment. Eleven percent of children experience significant impairment, and 5 percent experience extreme impairment. In raw numbers, an estimated four million children in the US experience a major mental illness that significantly affects their ability to function.[14]

The number of children at risk for mental health problems and in need of preventive care is much larger. While it is impossible to ascertain the exact number, some statistics can shed light on two sub-groups of children who are at risk. The estimated number of children who are maltreated in the US every year is more than three million.[15] Similarly, experts estimate that between three and ten million children witness domestic violence each year.[16]

The major types of disorders that affect children are anxiety disorders, disruptive disorders, mood disorders, and substance abuse disorders.[17] A general term that is used to describe children's emotional, behavioral, and mental disorders is **serious emotional disturbance (SED).** Although the definition of SED varies according to the source, the Center for Mental Health Services defines children with SED as:

> *persons from birth to age 18 who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in DSM-IV-R*, and have resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.*[18]

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* The *DSM-IV-R* is the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, the standard reference guide for classification of mental disorders published by the American Psychiatric Association.

Scope of the Problem:
Children's Mental Illness in Virginia

Overall Estimate

Determining the number of children and adolescents in Virginia who suffer from mental disorders is complex. Many children go untreated, and thus, uncounted. During the past several years, many attempts have been made to determine the number of children and adolescents with SED. According to the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the state agency responsible for delivering public mental health services to adults and children, between 9-11 percent of the population of children and adolescents suffers from SED. Five to seven percent of the population suffers from extreme impairment. In raw numbers, this means that as many as 64,000 children and adolescents in Virginia suffer extreme impairment from serious emotional disturbance.[19]

Youth Suicides in Virginia

The State Child Fatality Review Team reviewed the 58 suicides of children less than 18 years old that occurred in Virginia in 1994 and 1995 and reported the following statistics:

- More than half of the children had threatened to kill themselves or had previously attempted suicide.
- 60% of the female victims had received mental health services, while only 33% of the males had received these services.
- One-third of the youth (90% of whom were male) were involved with the juvenile justice or law enforcement systems.
- 34% of the youth had experienced abuse or neglect or had witnessed domestic violence in the home.

The team determined that more than half of the suicides they investigated were preventable.[27]

Prevalence of Youth Suicide

One particularly disturbing trend in the mental health of Virginia's children and youth is the increasing number of young people who take their own lives. According to the Virginia Department of Health, suicide is the third leading cause of death for young people in the Commonwealth. The rate of suicides for youth ages 10 to 19 has increased 32% since 1975, while the rate for the overall population has declined 27%. Although the rate of suicides for white youth is higher than that for non-whites, the rate of suicides by non-whites has increased dramatically in the last 25 years. According to the Surgeon General, boys ages 15-19 are about four times more likely to complete suicide than girls their age, but girls are twice as likely to attempt suicide.[20] Boys use firearms more frequently than girls, so their attempts are more lethal.[21] The estimated rate of suicide attempts to completions among adolescents nationally is estimated to be 50:1 to 100:1.[22]

Children suffering from depression are at a higher risk of killing themselves than are children without depression. At particular risk are children whose depression is coupled with conduct disorders and children who live in conflict-ridden families.[23] There are similar risk factors for girls and boys, including depression, previous suicide attempt, and substance abuse. Research has shown that a significant risk factor for youth suicide is a low level of communication between parents and children.[24] Gay and bisexual youth suffer from high rates of depression, and reports have shown they experience suicidal thoughts and attempts at three times the rate of other adolescents. Children who are exposed to ongoing community violence also experience an increased risk for suicide.[25] A gun in the home increases the risk of suicide in adolescents approximately four-fold; a handgun in the home increases the risk nine-fold.[26]

Stressful events, such as the breakup of a relationship, school difficulties, substance abuse, and getting into trouble with the law, often precipitate suicide attempts and completions but do not cause the suicide.[28] According to the American Academy of Pediatrics, a caring individual—such as a pediatrician, teacher, or parent—asking a youth about suicide does not increase the chances of that behavior. In many cases, such an inquiry lets the youth know that his or her cry for help is being heard and provides the opportunity for treatment.[29]

Occurrence of Mental Illness in Incarcerated Youth

A high percentage of youth in the juvenile justice system suffer from SED. According to a recent report from the Department of Juvenile Justice (DJJ), *Profiles of Incarcerated Adolescents in Virginia Correctional Facilities,*[30] 47% of males and 57% of females who are incarcerated have a designated mental health need. Many of these youth have a history of

Special Issue

Children Who Witness Violence

According to the National Institute of Mental Health, children who witness ongoing violence at home, at school, or in the community are at greater risk for developing long-term mental health problems than those who do not. Like adults, children who have experienced trauma can experience post-traumatic stress disorder (PTSD),[a] which occurs after a trauma that "constitutes a threat to life or physical integrity and elicits intense fear, horror, or helplessness."[b] PTSD alters certain brain mechanisms related to coping and other functions and is often accompanied by depression. Characteristics of PTSD include:

- re-experiencing the trauma through play, nightmares, or flashbacks;
- avoiding situations or reminders of the event;
- decreased interest in activities, loss of interest in the future;
- experiencing sleep disturbances, irritability, increased startle reaction, and regressive behavior.[c]

The estimated lifetime prevalence of PTSD among adolescents ranges from 3.5% to 8.1% and is due in large part to the increase in interpersonal violence, both in the home and in the community. Witnessing domestic violence, even when the child is not a direct victim of violence, results in a high risk of PTSD. In addition, multiple traumatic experiences increase the likelihood of developing the disorder.[d]

The consequences of untreated PTSD can be serious and long-lasting. A study of adolescents has shown that those who had experienced a trauma and suffered from PTSD were between 7 and 13 times as likely as those who had not to have another psychiatric diagnosis, most often major depressive disorder.[e] One study found that youth who had been exposed to community violence in Chicago were more likely than those who had not to exhibit aggressive behavior and be depressed within a year of being exposed to violence.[f] One of the most serious consequences of PTSD during the teenage years is the association with heavy alcohol and drug use. In addition to the direct negative effects of substance abuse, it can also increase the risk for further traumatic and violent experiences.[g]

Timely intervention for children who have experienced or witnessed traumatic or violent episodes can help reduce the likelihood of developing PTSD. One method that has been successfully used in hospital-based programs in Kansas City and Harlem is critical incident stress debriefing (CISD), a technique that is frequently used by police and emergency medical technicians after experiencing a particularly difficult case. CISD can be geared specifically for children, using play therapy and art therapy for those who are unable to express their feelings verbally. The purpose of CISD is to give children and adolescents the opportunity to discuss what they have experienced—to share their feelings about the incident from their perspective with someone who can provide additional information as to what actually happened. Often, just having their feelings acknowledged can help children cope more effectively with the event, and no additional therapy is needed. When a child needs longer term treatment, trained debriefers can provide referrals to a mental health professional.[h]

Jessica has been in and out of the juvenile justice system for years. At 17, she once again finds herself incarcerated after trying to assault a friend. Depressed and sad about her behavior, she finds a way to cut herself on the arm in jail. Her mental illness has been a major cause of her journey through this revolving door of mental health and juvenile justice services. Jessica's problems started when she was twelve, and treatment for her psychological problems has been inconsistent since that time. Private insurance paid for a therapist for only six months. She has received publicly-funded services through the local mental health center, but these have been interrupted by Jessica's trips into detention. Medicaid, which usually covers these services, does not cover mental health services for children in detention. Two things happen in Jessica's case: 1) Because it is not being reimbursed, the mental health center can only afford to provide very limited, crisis-oriented attention; and 2) Because Jessica has not been able to continue seeing her regular therapist during the month-and-a-half in detention, there is a good chance she might not continue her treatment at all. Left untreated, she will most likely spiral out of control again, and the cycle will repeat.

mental health treatment, ranging from therapy and hospitalization to use of psychotropic medications (those drugs used to treat mental disorders).

· More than 50% of both males and females who are incarcerated have previously participated in outpatient individual therapy, while 36% of males and 56% of females have previously participated in outpatient family therapy.

· An average of 17% of youth each year have previously been hospitalized for mental health treatment, with almost one-third of those having experienced multiple hospitalizations.

· From 1993-1998, the juvenile justice system saw a dramatic increase in the number of youths with a treatment history of psychotropic medication. While only 24% of youth had been treated with medication in 1993, more than 46% of youth had used medication in 1998. Females were more likely to have been treated with antidepressant and anti-anxiety medications, while males were more likely to have been treated with Ritalin for attention deficit/hyperactivity disorder. (See page 18 for a discussion of the overmedication of children.) In all cases, white youth were more often treated with medication than black youth.

How Mental Health Services Are Delivered In Virginia

As in all states, mental health services are provided in Virginia by both the private and public sectors. Families with private insurance, either through an employer-sponsored program or individual insurance plans, access services according to the regulations of that plan. Many private plans use separate mental health organizations to provide mental health benefits for the plan members. Coverage for mental illness is usually less extensive than for physical illness, making it more difficult and more expensive for families with mental health needs to access services. For example, many insurance plans limit the number of outpatient mental health visits per year and the number of days of inpatient treatment that will be covered. The federal government passed the Mental Health Parity Act of 1996, which went into effect in 1998, to address this issue, but the bill left major loopholes for insurance companies.[31] (See page 10 for a discussion of mental health parity.)

Because many families do not have private health insurance that covers mental health treatment, many children in Virginia access mental health services through the public sector—either state-operated facilities or, more often, community-based services. The agency responsible for managing these facilities and services in Virginia is DMHMRSAS. Funding for children's services in the public sector comes from Medicaid, state funds, and local funds for community-based programs. States are required by federal law to provide hospital inpatient and outpatient services for Medicaid eligible individuals, as well as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for children.[32] The federal government began offering State Plan Options, meaning additional Medicaid services, in 1986. Virginia began adding these additional services, called mental health rehabilitation services, in 1990. They include crisis intervention, intensive in-home services, targeted case management, and therapeutic day treatment.[33] Beginning in January 2000, treatment foster care was also added as a reimbursable mental health rehabilitation service.[34]

State-Run Mental Health Facilities

Virginia has followed the nationwide trend of moving away from institutional treatment of individuals with mental illness to community-based treatment. This is also the case with children's mental health services. Advantages of community-based treatment include

increased opportunity for family participation in treatment, proximity of the child to home, and increased ability to coordinate aftercare services.[35]

A number of children with severe mental health problems, however, need the intensive services of a psychiatric hospital. Since 1992, the number of beds in state mental hospitals has decreased from 172 to 64 with the closing of the children's unit at Eastern State Hospital (in Williamsburg) in fiscal year 1992; the transfer of the Virginia Treatment Center for Children to the Medical College of Virginia (in Richmond) and the subsequent reduction in beds for indigent children; the reduction in beds at the rebuilt Dejarnette Center (in Staunton); and the closing of the Adolescent Unit at Central State Hospital (in Petersburg) in July 1999. The remaining 64 inpatient beds (48 at Dejarnette and 16 at Southwest Virginia Mental Health Institute in Marion) must serve all children and adolescents statewide who require inpatient psychiatric care and have no insurance or Medicaid coverage, those whose insurance or Medicaid has run out, those whose behavior is so severe that private inpatient providers refuse to serve them, and all those in the custody of DJJ who require psychiatric care.[36]

Community-Based Treatment Options

Community Services Boards In Virginia localities, public sector mental health services are provided by Community Service Boards (CSBs). There are 40 CSBs in Virginia, and they are responsible for providing not only mental health services, but also mental retardation and substance abuse services for all 135 localities. CSBs are local governmental or quasi-governmental agencies. By law, CSBs are required to provide emergency services and case management services "subject to such funds as may be appropriated," and may provide a comprehensive range of other services.[37] No distinct services for children are mandated by law.

DMHMRSAS has identified eight "foundation" services that it would like all CSBs to implement for children: emergency services, specialized outpatient services, intensive in-home services, day treatment/education, individual therapeutic homes, case management services, respite care, and family support (meaning non-treatment services that help a family care for and live with a child with emotional, behavioral, or mental health problems). The mostly widely provided services across the Commonwealth are emergency services (provided by all CSBs), outpatient services, and in-home services.[38]

CSBs do not have the resources to serve all children in need. In fiscal year 1998, 22,390 children and adolescents received services from the 40 CSBs. Forty-three percent of these youth suffered from serious emotional disturbance. In a one-day, point-in-time survey conducted on June 1, 1999, the CSBs across Virginia reported a waiting list of 943 children and adolescents with or at risk of SED who were not currently receiving any services from the CSBs. An additional 3,003 young people were receiving some services, but not all they needed.[39]

System of Care Theory Much research has been done on the shift from institution-based to community-based mental health services. According to the research, community-based mental health treatment for children and youth should include a continuum of services that are available and accessible to families within a given geographic locality and make use of family and community support systems.[40] An ideal system of care recognizes that children with emotional, behavioral, and mental problems are affected in every aspect of their lives—home, school, and in the community. Mental health agencies alone cannot meet the needs of these children and their families. According to researchers, a system of care should be comprehensive, offering a full range of services from

SYSTEM OF CARE FRAMEWORK

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the least restrictive outpatient services to residential services, with each element coordinating with the others.[41] The system should also be responsive to individual children's needs and should include family input, building on the family's competencies and recognizing cultural differences. Finally, an ideal system would be cost-effective and accountable to stakeholders.[42]

The system of care model includes services in eight major areas: mental health, social services, education, health, substance abuse, vocational services, recreation, and operational services (which include case management, transportation, family support, and other services that cross all major areas). These services may be provided by a variety of different agencies, and there may be overlap in types of services, depending on resources and needs in a given community.[43] Effective case management is crucial so that families can navigate the array of service options for their children and so that services are coordinated rather than fragmented.[44] Systems that are severely lacking in one or more areas of service are unbalanced and, therefore, do not serve children as well. Because all elements of this system are interrelated, a shortage of services in one area will have a negative impact on the effectiveness of other service areas.[45]

Comprehensive Services Act for At-Risk Youth and Families (CSA)

State Executive Council
has oversight of the CSA.

Office of Comprehensive Services
serves as the administrative entity of the Council.

State and Local Advisory Team
advises the State Executive Council on state policies that promote interagency cooperation in the provision of services to trouble and at-risk youth and their families.

Community Policy and Management Team (CPMT)
is a local entity that makes policy and fiscal decisions regarding use of CSA funds in that locality.

Family Assessment and Planning Teams (FAPT)
are local teams that assess and create service plans for youth and families and make funding recommendations to the CPMT.

Comprehensive Services Act Virginia's response to the system of care model was the development of the Comprehensive Services Act for At-Risk Youth and Families (CSA), enacted by the General Assembly in 1992. The CSA streamlined funding that formerly went to several different state agencies for serving children with severe emotional and/or behavioral problems. This pooled funding is allocated to localities, where a collaborative team works together to coordinate services for children with input from families. (DMHMRSAS, which provides funding to local CSBs, is one of the agencies that collaborates as part of CSA. Thus, CSBs participate in these collaborative teams on a local level.) The goals of the CSA are to give localities the authority to make program and funding decisions for their communities; consolidate funding and encourage community responsibility for providing services; provide greater flexibility in the use of funds; and reduce disparity in service provision based on local match amounts for particular funding streams.

Each locality (or group of localities) has a Community Policy and Management Team (CPMT) that receives and administers funds and develops policies determining how these funds are used for children in its community within the eligible population.

Each locality also has one or more Family Assessment and Planning Teams (FAPT), which go by different names in different localities, to assess the needs of individual children and families. The FAPT is comprised of representatives from the local CSB, juvenile court services department, department of health, department of social services, and the school system. In addition, each FAPT has a parent representative. The FAPT is responsible for assessing the child with input from the family and developing an individual family services plan. The team refers youth to appropriate services, according to the plan, and makes funding recommendations to the CPMT. It is also responsible for monitoring the progress of the individual child/family. (See chart at left for CSA structure.)

To be eligible for funding under the CSA, a child must meet one or more of the following criteria:
· have an emotional or behavioral problem that a) has persisted over a significant period of time or is of a critical nature; b) is significantly disabling and present in several settings, such as home, school, and with peers; and c) requires services that are unavailable or inaccessible or that need to be provided and coordinated by two or more agencies.
· have emotional or behavioral problems and be in, or at risk of entering, residential care and require coordination of services by at least two agencies.

· require placement for purposes of special education in approved private school educational programs.
· be entrusted or committed to a local social services agency for foster care.
Localities are permitted under state law to charge fees for these services under a sliding fee scale, based on a family's ability to pay, so that parents contribute toward the cost of treatment.[46]

Within these eligibility requirements, children have been divided into two categories for funding purposes: children in foster care or in special education are *mandated* for funding, while other children who are eligible under CSA but not meeting those requirements are *non-mandated.* Whether non-mandated children receive services through the CSA is a local decision and depends on the level of funding in a given locality; many localities simply do not have the funds to provide services for these children, regardless of the severity of their needs. A 1998 study by the Supreme Court of Virginia estimated the number of non-mandated children at severe and acute risk for SED to be 20,661.[47]

Mental Health Services for Youth in the Juvenile Justice System

When youths are committed to DJJ, the first step is the Reception and Diagnostic Center, where all juveniles receive a mental health evaluation. Depending on children's needs and histories, assessment ranges from a structured interview to complete psychological testing. When juveniles are determined to have mental health needs, they receive treatment in the juvenile correctional facility from the department's mental health staff, including clinical social workers, psychologists, and consulting psychiatrists. Services include individual and group counseling, medication, and occasionally family therapy, if it is recommended and if family members are willing and able to participate.[48]

Mental health services for youth in the juvenile justice system are paid for by state funds. By federal law, youth are ineligible for Medicaid coverage once they become incarcerated.[49] Because such a small percentage of incarcerated juveniles have private insurance, DJJ does not deem it cost-efficient to bill third parties for most mental health services. As of July 1, 2000, DJJ had 68 full-time staff positions devoted to juveniles' mental health, as well as contracts with psychiatrists. The total mental health budget for DJJ is approximately $4 million per year. One-third of this amount is spent on specialized sex offender treatment.[50]

For youth in detention centers—who are not technically in the custody of DJJ—the level of mental health services depends on the local CSB. Funding to serve this population has been somewhat piecemeal. Some CSBs have applied for grants from state departments other than DMHMRSAS to treat youth in detention centers. DMHMRSAS provided funding to five CSBs beginning in 1995 for joint substance abuse and mental health services for youth in detention centers.[51] Children's services directors of CSBs report a general frustration with the lack of funding to serve this population. CSB counselors are required to "bill" for the majority of their time. As Medicaid will not cover incarcerated youth and a number of these youth do not have private insurance, many CSBs are left with no way to pay for these much-needed services.[52] Effective July 1, 2000, DMHMRSAS received a budget allocation from the General Assembly of $4.2 million to serve children who fall into the CSA's non-mandated population. This money can be used to serve youth in detention centers.[53]

John's older brother Matt has a serious mental illness. Matt has a lot of trouble getting along with his peers at school and with his siblings at home. When Matt gets home from school, he sometimes takes out his frustrations by beating up John. Matt receives special education services at school and extensive services at the local mental health center, but his condition has deteriorated over the last year. John's parents spend a lot of time taking Matt to appointments for school and to therapy. They have been very concerned about Matt's deterioration and spend much of their energy strategizing how to find the right kind of placement for him. Over time, John begins to get very anxious. He starts having trouble concentrating in school. Because his work begins to suffer, his school counselor eventually calls his parents to let them know how John is struggling. They call the mental health center to get John got involved in therapy. The therapist talks to John's parents about how John is suffering from a lack of attention from them—very similar to the type of experience siblings have in families with a medically needy child. Because of this new awareness of his needs, and with the assistance of family therapy, John's parents focus more of their attention on him. With help, John's emotional well-being improves.

Issues Affecting the Availability and Accessibility of Services

Given all the research about systems of care for children with mental health problems, why are more children and youth in Virginia not receiving the treatment they need? Since we know the devastating consequences for children, families, and the community at large when children do not receive necessary treatment, why are so many children still suffering? The problem is complex, and several major, interrelated factors have led to the present situation. Overall, there is lack of understanding about children's mental health problems, not just in Virginia, but throughout the country. This lack of awareness affects policy makers, service providers, and families themselves who are struggling with a child with emotional or behavioral problems.

Lack of Insurance Parity

Even for families who do have private insurance, adequate treatment is not always available. Mental health advocates have been making an effort over the last several years on both the federal and state levels to force insurance companies to provide insurance parity, meaning the same level of benefits for mental health treatment as for other types of treatment. Federal legislation, passed in 1996, states that insurance companies cannot provide different dollar limits for mental health treatment than for physical health treatment, but it leaves a major loophole: insurers can specify different length-of-care benefits, e.g., a limit of 20 mental health outpatient visits per year. This law applies to federal employees, military personnel, and self-insured plans (big businesses that pay claims with their own funds). President Clinton gave an executive order creating true parity for federal employees. Military personnel and employees under self-insured plans are still subject to insurance disparity.[54]

Virginians for Mental Health Equity, a coalition of mental health consumer and provider organizations, was formed in the late 1980s to advocate for mental health parity in state law, which affects all public and private employees not covered by federal law. This includes state employees and employees of smaller companies, which usually have fewer than 250 employees and have fully-insured plans (as opposed to self-insured plans). The state legislation provides more parity, forcing insurance companies to provide the same monetary limits, durational limits, co-payments, and medical necessity reviews for treatment of serious, biologically-based mental illness as for any other kind of treatment. Passed in the 1999 General Assembly session, the legislation went into effect on July 1, 1999, for state employees and January 1, 2000, for other employees. An attempt was made in the 2000 legislative session to limit the parity for certain small companies, but the effort was defeated.[55]

Complexity and Limits of Medicaid Regulations

Complex Medicaid regulations often create barriers for families trying to access services for their children. For example, regulations stipulate that outpatient psychiatric services must be delivered in an office or clinic, which can create a barrier for those who are not likely to access services in that setting. It rules out the possibility of providing children's services in a community center or other place where children naturally congregate. Regulations on acute care are also strict, allowing a maximum of a seven-day stay, which is not long enough for many children who need inpatient psychiatric care.[56]

Virginia, like other states, has established a system of children's insurance for families who neither qualify for Medicaid nor can afford private insurance. Virginia's plan was originally called CMSIP, the Children's Medical Security Insurance Program, and was based on a Medicaid model, meaning the benefits and providers were the same as for Medicaid-eligible families.[57] The 2000 General Assembly changed the plan to an employer-sponsored insurance plan called FAMIS, Family Access to Medical Insurance Security Plan. This new plan, which will take effect as soon as the state has approval from the federal government, is not based on Medicaid. In FAMIS, the state is encouraging families who can access insurance through work to enroll their children in those plans, and the state will reimburse them. For

those families who do not have access to employer-sponsored insurance, the state will provide an alternative.[58]

Coverage for mental health services under FAMIS will change somewhat from the CMSIP/ Medicaid coverage. First, FAMIS will provide coverage for more outpatient visits than CMSIP (50 per year vs. 26 per year), as well as longer inpatient stays (30 days vs. 7 days). Coverage for community-based services, however, decreases under FAMIS, which could have drastic implications for families who need these services to keep their children in their own homes and communities. Although the plan has not yet received final approval, it appears that community services such as intensive in-home care and therapeutic day treatment will not be covered.[59]

Lack of Public Funding for Services

Piecing together funding for children who do not have private health insurance is a difficult task for families and for those trying to provide services. DMHMRSAS provides some funds for CSBs that are specifically designated for children's mental health services. Beyond those dollars, it is up to the local CSBs to determine how much of their general allocation from DMHMRSAS they will earmark for children's services.[60] In fiscal year 1998, just 6.9% of the total dollars controlled by DMHMRSAS, or $20.7 million out of a total of more than $298 million, were designated specifically for children's mental health services by DMHMRSAS.[61] Some of the CSBs' general allocation funds were also spent on children's services, but DMHMRSAS does not analyze this information in such a way as to make this figure available.[62] Due to a lack of awareness about the extent of children's mental health issues—even by service providers themselves—most CSBs provide relatively little funding for child and adolescent services.

The Stigma of Mental Illness

Both children and adults with mental illness often feel embarrassment and shame that those with a physical illness do not. Families of children with mental health problems are particularly stigmatized, as they are often blamed for their children's illness. A national survey of parents for the National Association of Mental Illness, conducted by the Commonwealth Institute for Child and Family Studies at Virginia Commonwealth University, found that having a child with mental illness can be a very isolating experience for a family. Roughly half of the respondents reported that they felt "shunned" by friends and neighbors because of their child's problems and that they were blamed for those problems. With this lack of support, marriages are often strained and siblings of children with mental illness are negatively impacted. One parent reported that her child without mental health problems said that she suffered from post-traumatic stress disorder after going to college as a result of living in a family that was trying to cope with a child with mental illness.[63]

In addition to the emotional burdens, there are often overwhelming financial burdens for families; parents may have to change jobs or quit working altogether to care for a child with serious emotional, behavioral, or mental disorders. Even parents who have private insurance may not be able to access needed services for their child in states that do not have insurance parity, and are thus stigmatized by the health care system.[64]

Nationally, an effort has been made to include families in treatment plans and to offer services that support them rather than stigmatize them. Families report that emotional support is the most important tool for helping them cope. Supportive services for families can come in the form of family support groups, education for families about the particular emotional or behavioral problem being experienced, and practical support such as respite care to provide a break

Pete was horribly abused before he was placed in foster care when he was two years old. He had been sexually molested repeatedly by members of a cult and at one point had been tied to a tree and abused. When Pete was four, his foster parents adopted him. Despite their love and attention, Pete still had difficulty in elementary school, hitting kids and behaving very hyperactively. Pete's parents decided to home-school him. At age 12, Pete's problems escalated: he began to hoard different items at home and to steal from department stores. He would lie repeatedly about his behavior. He became sexually involved with his foster sister and was sexually inappropriate with other women and girls. Already receiving one-hour-a-week family therapy, Pete's parents were referred to the local mental health center for more intensive help. Because of the seriousness of his problems, the local mental health center recommended a residential treatment program for Pete. Finding funding for this treatment, however, became a difficult issue. Despite the availability of funds for children with educational needs like Pete's, the school refused to help pay for the educational components of this very expensive treatment program because Pete had not been enrolled in the school system for several years. Fortunately for Pete, because he had been adopted through the local department of social services, it was able to fully fund his treatment.

for caregivers.[65] On a system-wide level, efforts to enact mental health parity legislation—such as by Virginians for Mental Health Equity—will help reduce the institutionalized stigma of mental illness for families.

When Jason was a young child, his father sexually abused him. His father also beat Jason's mother, Mrs. Jones. Later, after her son experienced difficulty getting out of bed and going to school, Mrs. Jones turned to the local, public, human-services agencies for help. Instead of addressing the underlying causes of his emotional problems, he was sent to detention for being truant. Jason's condition deteriorated upon release. This began Mrs. Jones' years-long struggle to get her son the help he needed. Over the years, they were offered a range of services from multiple agencies, each addressing a different part of his problems. Jason cycled through special education program to treatment center to detention and back again. When Mrs. Jones eventually did find a school Jason liked, the community, tax-based funding source (Comprehensive Services Act) would not pay for it. Always dealing with different counselors was difficult. Some programs were helpful, others not. Reflecting on her experience, Mrs. Jones wonders: Where was the public agency that could've worked with Jason and her in their home and community consistently over the years, that could have taken a holistic, integrated approach to his problems rather than breaking his treatment up into different services-determined pieces?

Consequences of Stigma and Scarce Resources for Children's Services

Funding Designated for Specific, Limited Populations

The scarcity of public funds led the DMHMRSAS to establish a system of priority populations so that services are available for those who need them most. This system is used for allocating state-controlled funds, which include state general funds and federal funds allocated by the General Assembly, Medicaid Mental Health Rehabilitation Services funds, and local matching funds. Those who fall in one of the priority populations are not guaranteed services, but are given highest priority. This system has been field-tested over the last several years and went into effect across Virginia in July 2000.[66]

The definition of the priority population for children and youth is a) children and adolescents, birth though age 17, with SED, and b) children, birth through age 12, who are at risk of developing SED.[67] Eventually, funding for CSBs will be determined based on performance measures related to increased service of priority populations.[68]

Under the system of priority populations, two tiers of services are available to both adults and children with mental health issues. Short-term intensive intervention services (for those experiencing a crisis) should be available to anyone who needs them. Longer term services are available only to those in the priority populations. More and more, CSBs are limited to serving only children with the most extreme emotional and behavioral problems. Those showing early warning signs of problems are unable to get treatment until their situation deteriorates and they meet the definition of a priority population.[69]

Juxtaposed to the priority population regulations are the regulations of the CSA, which control separate funding streams. In most localities, CSA funding is only available for the mandated population (children in foster care and special education), and not for non-mandated children no matter how severe their mental problems may be.[70]

Continuum of Services Not Available

Although experts agree on the type of service delivery system that would best serve children and families, scarce resources mean that this system is not close to being in place in most localities in Virginia. DMHMRSAS outlines eight "foundation" services that CSBs should develop for children with SED. A 1998 survey of CSBs indicates that more than 50% of the CSBs are providing five or more of these core services. While this is encouraging, it also means that almost half of the CSBs are providing four or fewer of the eight necessary services.[71] This means, for example, that a family who has a child with SED may only have limited outpatient services available in their area. If their child needs more intensive services, day treatment may not be an option. Nor would they have respite care, which can help the family keep the child in their home longer by providing needed breaks for caregivers. A 1999 report by the Virginia Department of Health indicated that Virginia's ratio of mental health providers to population falls below national averages.[72]

In addition, the continuum is not in place to provide a smooth transition for youth who "age out" of children's services when they turn 18. To be eligible for adult services, they must meet the criteria for the adult priority population, which is severe mental illness. As a result, there is a large gap in services for the 18-to-25 age group. Many of them will eventually qualify for services, but a serious mental illness could possibly be prevented if they could continue with ongoing treatment at age 18.[73]

Parents Forced to Relinquish Custody of Children

In Virginia, as in other states, parents are sometimes required to take the last-resort measure of relinquishing custody of their children in order to access treatment for them. There appear to be four main reasons for this situation:

1. *Financial Reasons:* Child welfare staff wrongly assume that state funds are available for out-of-home treatment only if children are in custody of the state. This is a misinterpretation of Public Law 96-22, the Adoption Assistance and Child Welfare Act of 1980, which allows voluntary placement of children in out-of-home facilities. The court becomes involved only when reimbursement is required for a stay in excess of 180 days.
2. *Legal Liability:* Again, some child welfare staff assume that the state's legal liability is decreased if the child is in the custody of the state when placed in out-of-home treatment programs. There is no support for this assumption.
3. *Treatment Considerations:* Some child welfare staff seem not to want parents to be involved in their child's treatment. This is an outdated model that asserts that contact with the parents impedes the child's progress in treatment.
4. *Resource Scarcity:* With a shortage of treatment facilities in many states, including Virginia, children who are in the state's custody get first priority for treatment. Parents are forced to make the difficult decision to relinquish custody to give their children the opportunity to access needed services.

Parents often feel guilt and loss when they are required to relinquish custody of their children to access inpatient treatment. Separation is especially difficult for children with serious emotional disorders and can contribute to a child's feelings of worthlessness. Parents also tend to have less involvement in their child's treatment when they have relinquished custody, which has been shown to correlate to longer hospital stays.[74]

Children Committed to Department of Juvenile Justice for Services

Among many professionals in the field, as well as among parents trying to access mental health services for their children, there is an increasing perception that the juvenile justice system is used as a "dumping ground" for children and youth with mental health problems. Often, youth who are sent to juvenile correctional facilities have a history of involvement with the mental health system, but they have not received adequate services. Funding restrictions make it difficult for CSBs to access inpatient or residential services for youth and difficult for DJJ to access community services. Thus, some youth are shuttled back and forth between the mental health and juvenile justice systems, never really receiving the treatment they need.[75]

When children with mental health disorders enter juvenile facilities, localities may not have the resources to provide the necessary services. Detention centers in particular, where juveniles are sent before and sometimes after disposition, or sentencing, generally have few mental health services.[76] While a few CSBs have staff positions dedicated to serving the needs of juvenile offenders, most CSBs do not have funding to provide this service.[77] Furthermore, Medicaid does not cover mental health services for incarcerated individuals.[78]

Lack of Prevention and Early Intervention Efforts

With public mental health funds targeted to children and youth with the most severe problems, few resources are left to address prevention and early intervention efforts. Primary prevention efforts are directed at those children and families who have not yet been identified as having mental health issues and, generally, are targeted to those who are at higher risk.[79] As prevention services are one component of the system of care, agencies other than just mental health agencies must become involved in prevention efforts.

One area of prevention lies in reducing the risk factors that lead to mental illness in children. Research has shown that "there are multiple pathways to most psychological disorders. That is, different combinations of risk factors may lead to the same disorder and no single cause may be sufficient to produce a specific negative outcome."[80] The same risk factors that influence mental health also can lead to social problems and health-risk behaviors in youth. So a prevention model that targets a variety of risk factors may have positive effects on social development and physical health as well as on mental health.[81]

Mrs. Weaver sought treatment for her daughter from therapists covered by her insurer—a mental health managed-care HMO. None of the HMO-approved therapists was accepting new patients, so Mrs. Weaver contacted Dr. Richards, a psychiatrist new to the area, to find out if she could see her daughter for psychotherapy for an hour a week. In exasperation, Mrs. Weaver told the doctor that all the therapists she had contacted who accepted her insurance were fully booked with patients and could not see her daughter. Dr. Richards, having heard the same story from other parents, called the insurance company to see if she could become an approved provider. To be approved and become part of their "panel" of providers, the therapist must meet the HMO's eligibility criteria and navigate the very complicated paperwork process, and the insurance company must be willing to add a therapist to their rolls. Dr. Richards left several messages at the number set up specifically for this purpose and received no return call. Through Dr. Richards' research, she got in touch with someone else in the company who said he would review her credentials. Dr. Richards faxed these to him. She never heard back from the insurance company. How is Mrs. Weaver going to find a therapist for her daughter?

In addition to trying to prevent risk factors, prevention models also seek to increase protective factors, or those elements that reduce the likelihood of negative outcomes despite the presence of risk factors. Protective factors include nurturing individual characteristics in children, such as cognitive and social skills, improving the quality of children's interactions with others, such as parents and peers, and making changes in children's environments, such as the quality of schools.[82] As many adult mental illnesses have their roots in childhood problems, investing in prevention efforts is necessary to avoid wasting the country's financial and human resources.[83]

Examples of primary prevention strategies include school-based violence prevention programs and programs designed to build children's social and emotional skills. Promoting Alternative Thinking Strategies (PATHS) is an elementary school-based program that teaches children to identify, understand, and self-regulate their emotions. Importantly, the program includes components for parents and non-classroom staff so that they can reinforce the skills children are learning in the classroom. Evaluation of the program has shown its effectiveness for both regular education students and those with special needs in improving students' social problem solving, self-report of conduct problems, and teacher ratings of adaptive behavior. This approach has shown positive effects on behavior problems even two years after the intervention. Responding in Peaceful and Positive Ways (RIPP), a violence prevention curriculum being piloted in middle schools in Richmond, has been shown to have some success in reducing weapon carrying and in-school suspensions. Through the use of small group and team-building activities, role-playing, and relaxation techniques, students are taught communication skills and non-violent methods of conflict resolution.[84]

Secondary prevention is targeted to children and families who have already been identified as having mental health problems and is based on the belief that early identification and treatment can reduce the duration and severity of the problem, as well as the need for costly treatment later on. Physicians and nurses often play an important role in recognizing the early onset of problems, as they are the most likely professionals to interface with the family during infancy and early childhood. Professionals in child care centers and schools also need to be able to respond to parents' concerns about their children's development and recognize signs of early problems. An effective early intervention program requires the coordination of many systems that work with children,

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hence its inclusion as a component in the system of care model.[85] Newer intervention models that focus not only on the child who is showing early signs of a disorder, but also on parents, teachers, and peers, have shown the most promise because they address the problem in a variety of settings, including home, school, and neighborhood.[86]

Head Start programs are a natural place for prevention and early intervention efforts to take place, as mental health has been identified by Head Start nationally as a critical component of child development. New Performance Standards for Head Start programs stipulate that a licensed mental health professional must be on site regularly enough to develop relationships with children and their families. Historically, however, many local programs have experienced difficulty in finding qualified professionals to provide these services, as well as funds to pay for them. Centers report an increasing number of children acting out violently against their peers as a result of increased stress at home and in their communities, but many Head Start staff do not have the training or expertise to be able to handle these children's behaviors.[87] In the Commonwealth, the Virginia Head Start Association's Health Advisory Committee supports a subcommittee on mental health to address these issues. Some of the goals of this subcommittee are to provide a link between Head Start and DMHMRSAS, to share information with each other about successful mental health services within individual programs, and to provide training for teachers and families on working with children with challenging behaviors.[88]

Recommendations

Based on the preceding information about the state of children's mental health services and the need for those services in Virginia, the Action Alliance for Virginia's Children and Youth offers the following recommendations:

1. Increase the general public's awareness and knowledge of children's mental health issues. Public education and awareness activities need to inform individuals, from parents to legislators, about the existence, prevalence, and ramifications of children's mental health issues. Heightened awareness can lead to a decrease in the stigma associated with mental illness. It can also encourage citizens to demand better services, and offer youth, parents, and other caregivers information about resources for mental health services. In 2000, the General Assembly authorized the development of a Virginia Youth Suicide Prevention Plan by the Commission on Youth, the Department of Health, DMHMRSAS, and others. An important component of this plan is the public awareness campaign regarding youth suicide and depression, which will begin to address this issue.

2. Increase the effectiveness of advocacy for children's mental health services. A number of organizations in Virginia are active in advocating for children and adults with mental illness. These include the Mental Health Association of Virginia, the National Alliance for the Mentally Ill - Virginia, the Virginia Association of Community Services Boards, and the Federation of Families for Children's Mental Health. More organizations and individuals need to join the cause so that real change can be effected in the Commonwealth, and these advocates need to be better organized and to coordinate their efforts. Advocacy can be on different levels—advocating for services for a specific child, or on behalf of all children on a local, state, or national level. The Action Alliance is forming a statewide coalition on children's mental health issues and invites both individuals and organizations to join. The coalition will conduct advocacy activities on both a local and statewide level. Please contact Margaret Nimmo, Senior Program and Policy Director, at (804) 649-0184 or margaret@vakids.org for more information.

3. Increase the focus on prevention and early intervention services. Private and public providers of mental health services, as well as decision makers who develop the

policies affecting these providers, need to understand and devote resources to prevention activities. Providing children and adolescents with prevention and early intervention when they are at-risk or at the first stages of a problem is the most compassionate thing for the children and their families. So much human potential is wasted when children do not get the mental health care they need in a timely manner. In addition, emphasizing prevention makes good economic sense. It is far less expensive to intervene when children are young or first showing signs of mental distress than to pay for costly residential services or incarceration later down the line.

4. Establish community-level and state-level commitments to the system of care model. Research in the field of children's mental health has shown what type of service system is effective in treating children with mental health problems. The system is extensive and does not work well when many pieces are missing, as they currently are in many localities in Virginia. Establishing systems of care will mean looking at service delivery in a creative way and collaborating with those in other disciplines. A child with a mental health problem is not just affected at school or at home, so agencies representing every aspect of his or her life need to be involved in treating the child. Services need to "wrap around" children and families with mental health issues. Funding sources, whether public or private, need to understand that additional resources will be necessary to establish the system of care, but money spent on mental health services today will save money later in the correctional and social services systems.

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[101] *Surgeon General*, p. 156.
[102] Zito JM, *et al.* "Trends in the Prescribing of Psychotropic Medications to Preschoolers." *Journal of the American Medical Association*. February 23, 2000. 283(8):1028.
[103] *Ibid*, p. 1029.
[104] *Ibid*, p. 1025.
[105] Clay RA.
[106] *Ibid.*

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[4] National Institute of Mental Health.
[5] Deykin EY.
[6] *Ibid.*
[7] National Institute of Mental Health.
[8] Deykin, E.Y.
[9] Personal communications with Margaret Dolan of Medical College of Virginia, and from concept paper for Child Violence Intervention Project.

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OVERMEDICATION OF CHILDREN

A national debate has arisen over the past several years regarding the increase in prescribing psychotropic medication (those drugs used to treat mental disorders) for children. Of particular concern are the number of prescriptions written for stimulants, such as methylphenidate (Ritalin) and selective serotonin reuptake inhibitors (SSRIs) like Prozac.

Methylphenidate is frequently prescribed for children with Attention Deficit/Hyperactivity Disorder (ADHD), the most commonly diagnosed behavioral disorder in children. According to the Surgeon General, ADHD occurs in 3 to 5% of school-aged children in a six-month period.[89] Methylphenidate is now being manufactured at 2.5 times the rate it was ten years ago.[90] In the last ten years, the number of Ritalin prescriptions, the per capita distribution of the drug, and the number of patient visits for ADHD have increased three- to six-fold.[91] This has led some researchers to question whether children are being overdiagnosed with ADHD.

A study of ADHD prescriptions in different Virginia localities suggests that there are important regional differences in the way ADHD is diagnosed and treated. Concern about overprescription of methylphenidate in the Commonwealth came to a head when data showed that in 1995, Virginia had the highest per capita distribution rate of the drug of any state.[92] A study conducted in two school systems in the Hampton Roads area found that 8% to 10% of the children in grades 2 through 5 took medication at school for ADHD. This rate is two to three times the national average.[93]

Overdiagnosis of ADHD could be a result of physicians not following the established diagnostic criteria, so that children who show some but not all of the criteria for ADHD are being prescribed stimulants. Diagnosis of ADHD should be based on information gleaned from multiple sources (e.g., parents, teachers, children) with several different instruments, which takes time and expertise.[94] The doctors most likely to prescribe stimulants for ADHD, however, are general practitioners, not psychiatrists or pediatricians. In some areas of the country, such as rural areas, there are not experts in psychopharmacology to advise general practitioners, so they may be writing prescriptions with a lack of information.[95] The American Academy of Pediatrics insisted at its annual meeting in 1999 that screening children for ADHD and coexisting conditions, such as learning disorders, need not be done by specialists. The Academy has developed new guidelines for pediatricians to diagnose ADHD, requiring them to obtain information on the child's symptoms from multiple settings, among other things.[96]

Despite the increase in Ritalin prescriptions, the Surgeon General reports that not all children with ADHD are being treated, particularly girls and minority children.[97]

Abuse of Ritalin by youth is also a concern for some. The US Drug Enforcement Administration (DEA) reports that methylphenidate is one of the pharmaceuticals most frequently reported stolen and that its abuse can lead to dependence. National studies have revealed that children give and sell their Ritalin prescriptions to other children. Inhaling crushed Ritalin is blamed for two student deaths that occurred in March 1995, one in Virginia.[98]

SSRIs are used to treat depressive disorders. It is estimated that between 10-15% of the child and adolescent population suffer from some of the symptoms of depression at any one time, but that 5% of children ages 9 to 17 suffer from a diagnosis of full-fledged depression.[99] According to the American Psychological Association, physicians wrote as many as 735,000 prescriptions for SSRIs for children ages 6 to 18 in 1996. This represents an 80% increase in two years.[100] One possible explanation for the increase

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is the growing reliance on SSRIs instead of on tricyclic antidepressants, the predecessors of SSRIs. Research has shown that tricyclic antidepressants are ineffective in children, while initial research has shown SSRIs to be more effective.[101]

A study published in the February 2000 *Journal of the American Medical Association* highlighted the sharp increase in prescribing psychotropic medication to preschoolers. Studying data from three geographically distinct areas of the country, the researchers found a three-fold increase in prescribing stimulants from 1991 to 1995. Ninety percent of stimulant prescription was for methylphenidate (Ritalin). Use of antidepressants also increased significantly, with tricylcic antidepressants being prescribed most frequently. The use of SSRIs, however, increased with this population as well.[102] Antidepressants are used fairly commonly to address bed-wetting in children ages 5 to 13, but the researchers found the increase in its use for preschoolers to be "puzzling."[103]

A major concern given the increasing use of psychotropic medications for young children is the lack of research on the effects of these drugs on child development. Prescribing these drugs for preschoolers is considered "off-label" use because the drugs lack package insert labeling information by the US Food and Drug Administration (FDA), meaning their use for this population of treatment has not been proven effective.[104] Lack of research also means that there are no guidelines for proper dosages for children this young. To address this issue, President Clinton ordered the FDA to show that drugs prescribed for children are safe, and the National Institutes of Health have recently begun a series of related studies.[105]

Some critics argue that placebos are just as effective as psychotropic medications because a diagnosis of ADHD and a prescription result in increased attention from parents and teachers, which improves symptoms. Other doctors emphasize the need to look at a child's environmental factors when symptoms of mental health problems appear, rather than rush to prescribe medication. Factors such as nutrition, sleep patterns, and home environment all play an important role in children's mental health.[106] Treatment with medication is often cheaper than treatment with psychotherapy or a combination of the two, and, unfortunately, economics often influences insurance companies and managed care organizations.[107]

Some related contacts:

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National Mental Health Association
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The Action Alliance for Virginia's Children and Youth is the Commonwealth's nonprofit, multiple-issue child advocacy organization. The mission of the Action Alliance is to build a powerful voice for children and to inspire the people of Virginia to act on their behalf. The work of the organization focuses primarily on three core issues: children's health, early care and education, and the prevention of violence.

The Action Alliance, founded in 1994, is a membership organization with members from throughout the Commonwealth. Through expertise in connecting resources, in providing accurate and objective information, and in educating key groups and individuals, the Action Alliance is a unique catalyst in implementing long-term, systematic, positive change for Virginia's children and youth.

For information on membership in the Action Alliance, or about any of its projects, contact:

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The Action Alliance is forming a statewide coalition on children's mental health, open to professionals, parents, citizens, and youth who are concerned about children's mental health and well-being. For more information about joining the coalition or about the Action Alliance's initiatives on mental health in your area, contact Margaret Nimmo at (804) 649-0184 or at margaret@vakids.org.